MARYLAND
INSURANCE
ADMINISTRATION

REPORT ON THE USE OF THE MEDICAL LOSS RATIO

DECEMBER 2009

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Executive Summary

The medical loss ratio is a statistical measure of the relationship between claims and premiums. Regulators consider the medical loss ratio when evaluating rates to make sure a reasonable amount of the premium dollar is allocated to the cost of benefits. Thirteen states, including Maryland, have established minimum loss ratios in the individual or small group market carriers must meet. No state has used the medical loss ratio as an incentive to change health plan activities. The medical loss ratio should remain a tool used by the Maryland Insurance Administration to assess premium rate filings. It should continue to be publicly disclosed by the Maryland Insurance Administration and health plans to allow consumers to consider whether a reasonable amount of the premium dollar is allocated to the cost of benefits.

Introduction

Chapter 509 of 2009 directed the Maryland Insurance Administration ("MIA"), in consultation with the Maryland Health Care Commission ("MHCC") and appropriate stakeholders, to study options to raise or define medical loss ratio requirements in the individual, small group and large group insurance markets that incentivize reduction of health care costs and improvement of health care quality.[1]

The report begins by reviewing the medical loss ratio and its use. It then addresses each of the questions raised in Chapter 509. Based on this review, the MIA recommends the medical loss ratio remain a tool to use during the rate review process and for consumers to use, along with other publicly available data, when reviewing health plans.[2]

Medical Loss Ratio

The medical loss ratio is a statistical measure of the relationship between claims and premiums. A wide variety of audiences use the medical loss ratio.[3]

- Regulators consider the medical loss ratio when evaluating rates to make sure a reasonable amount of the premium dollar is allocated to the cost of benefits.
- Investors and investment analysts use medical loss ratios to track trends in a company's earnings.
- Health plan management may use medical loss ratios to set target premiums and determine rate increases.
- Consumers use medical loss ratios to compare the performance of health plans; those with the highest medical loss ratios are seen as best for consumers as they return the highest proportion of premium dollars in benefits.

A recent survey of health care opinion leaders showed 54% strongly support public reporting of health plan medical loss ratios.[4]

Whether the medical loss ratio is a useful tool for comparing health plans is a subject of debate.[5] In part, the controversy over the medical loss ratio lies with how it is calculated and reported.

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[1] The MIA would like to acknowledge the input provided by the Executive Director of the MHCC to an earlier draft of this report. Staff from the MIA and the MHCC jointly shared a draft of this report with provider and health plan representatives. Health plan representatives provided more up-to-date information about medical loss ratios in other states. Provider representatives noted the limitations of the medical loss ratio. None of the stakeholders expressed disagreement with the MIA's conclusions.

[2] The term "health plan" is used here to refer to insurers, health maintenance organizations and nonprofit health service plans offering insured health benefits to individuals, small groups, and large groups.

[3] For additional information, see *"Loss Ratios and Health Coverages,"* Loss Ratio Work Group, American Academy of Actuaries, November 1998.

[4] See *Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States,* the Commonwealth Fund.

[5] See Robinson, James *"Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," Health Affairs,* Volume 16, Number 4.

Calculation of Medical Loss Ratio

The most commonly used calculation for the medical loss ratio was developed by the National Association of Insurance Commissioners (NAIC). The NAIC directs health plans to calculate the medical loss ratio by dividing incurred claims by earned premium for the specific calendar year. The total amount for incurred claims includes claims paid, reserves for active claims, and claims incurred but not reported. Thus, the total amount for incurred claims is based on the health plan's best estimate of total claims payment for the specific year.

There are two general critiques of the medical loss ratio. First, because health plans have different methods for estimating reserves for active claims and for claims incurred but not reported, the medical loss ratio cannot be used to compare health plans. Second, with the growth of managed care, the medical loss ratio discounts health plan activities devoted to controlling health care costs such as provider contracting and care management.

State Medical Loss Ratio Requirements

Thirteen states have set minimum medical loss ratio requirements in the commercial health insurance market. As Table 1 shows, these requirements apply only to products sold to individuals and small groups.

Table 1: Medical Loss Ratio Requirements

State	Individual Market	Small Group Market
Delaware		75%
Kentucky	65%	70%, 2-10 employees 75%, 11-50 employees
Maine	65%	75%, if file rates annually 78%, if file rates every 3 years
Maryland	60%	75%
Minnesota	72%, if more than 3% assessment for MCHA* 68%, if less than 3% assessment for MCHA	82%, if more than 3% assessment for MCHA If less than 3% assessment for MCHA: 71%, 2-9 employees 75%, 10-50 employees
New Jersey**	80%	80%
New York**	75%	75%
North Dakota	55%	70%
Oklahoma		60%
South Dakota	65%	75%
Vermont	70%	
Washington	77%	
Wyoming	60%	73%

Source: *"Medical Loss Ratios: Evidence from the States," FamiliesUSA*, June 2008
* MCHA: Minnesota Comprehensive Health Association
** Updated based on information provided by America's Health Insurance Plans

If health plans, in the aggregate for each market, do not meet these minimum loss ratio requirements, the health plans may be required to reduce the premiums charged for their products or issue refunds to policyholders.

Maine, New Jersey and New York have required health plans to issue refunds to policyholders. In 2008, two health plans in Maine refunded policyholders $7.6 million. Between 1993 and 2006, health plans in New Jersey were required to refund $11.6 million to policyholders in the individual market. In New York, Oxford Health Insurance was required to refund $50 million to 37,000 small businesses.[6]

Maine (Appendix 1), Maryland (Appendix 2), New Jersey (Appendix 3), and Minnesota (Appendix 4) insurance departments publicly disclose medical loss ratios. Additionally, in Maryland health plans are required to disclose the proportion of every $100 in premium dollar used to pay providers for health care services and to pay for plan administration. See *Insurance Article* §15-121. Public disclosure allows consumers to consider the amount of the premium spent on benefits.

Of these thirteen states, only Minnesota reviews the medical loss ratio and the cost containment ratio. The cost containment ratio is calculated by dividing the amount of expenses allocated to cost containment by earned premium. Cost containment includes a number of activities:

- Case management activities
- Utilization review
- Detection and prevention of payment for fraudulent requests for reimbursement
- Network access fees to preferred provider organizations
- Consumer education solely relating to health improvement and relying on direct involvement of health plan personnel
- Expenses for internal and external appeals processes

Cost containment accounted for 2% of premium in 2008 in the individual market, ranging from 0 to 4% by health plan and 1% of premium in the small group market, ranging from 0 to 2% by health plan.

States do not use the medical loss ratio to assess quality. The reason for this is simple: ". . . neither premiums nor expenditures by themselves indicate quality of care. More direct measures of quality are available, including patient satisfaction surveys, preventive services use, and severity-adjusted clinical outcomes."[7] The MHCC annually publishes a report on the quality and performance of health maintenance organizations and preferred provider organizations.

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[6] See *"Medical Loss Ratios: Evidence from the States," FamiliesUSA*, June 2008.
[7] See Robinson, page 178.

Policy Questions

The General Assembly asked the MIA, in conjunction with the MHCC, to address a number of policy questions about the medical loss ratio. These are discussed below.

- *Can the medical loss ratio be used to incentivize health plans to reduce health care costs and improve health care quality in the individual, small group, and large group markets?*

The medical loss ratio is a measure of the relationship between claims and premiums. It is not a measure of quality or value. No state has used the medical loss ratio as an incentive to change health plan activities. Rather, it is primarily used by regulators and consumers to consider how much of the premium is devoted to claims over time and across plans.

Minnesota has directed health plans to calculate the cost containment ratio. This allows regulators and consumers to consider how much of the premium is devoted to cost containment overtime and across plans. It is not clear that this has changed health plan behavior.

- *In reviewing other states' medical loss ratio requirements, do they have innovative ways to encourage health plans to incentivize adoption of electronic health records, implement wellness programs, implement chronic care management programs, and adopt other policies that reduce health care costs and improve health care quality?*

Other states do not use the medical loss ratio to encourage health plans to engage in specific activities and do not use the medical loss ratio to monitor or evaluate health plans in these specific activities.

- *What has been the impact of tiered medical loss ratio requirements in other states?*

Minnesota has tiered medical loss ratio requirements. Minnesota publicly reports only the overall medical loss ratio for a health plan in the individual and small group markets. The impact of a tiered medical loss ratio is not clear.

Conclusions

In some states, regulators use the medical loss ratio when evaluating rates to make sure a reasonable amount of the premium dollar is allocated to the cost of benefits. It is not the only factor regulators use when evaluating premium rate filings. For example, when reviewing a premium rate filing, the MIA considers:

- Enrollment data, current rates, proposed rates and percentage change
- Projected income and expenses with and without a rate change
- Cost and utilization trend assumptions
- Tests of the accuracy of the health plan's past trends

For the individual and small group markets, if a health plan's medical loss ratio is below the statutory minimum required, the MIA assesses whether the proposed premium will increase the medical loss ratio; if the proposed premium will not increase the medical loss ratio above the statutory minimum, the MIA asks the health plan to adjust its rate filing.

Some states publicly disclose medical loss ratios by health plan and by market. This allows consumers to also see if a reasonable amount of the premium dollar is allocated to the cost of benefits.

States do not use the medical loss ratio as a tool to modify health plan behavior. Given the specific characteristic of the measure, it is not appropriate to use the medical loss ratio in this way.

Based on the review of the medical loss ratio, the MIA does not recommend modifying the use of the medical loss ratio. It should remain a tool used by the MIA to assess premium rate filings. The medical loss ratio should continue to be publicly disclosed by the MIA and health plans to allow consumers to consider whether a reasonable amount of the premium dollar is allocated to the cost of benefits.

APPENDIX 1: MAINE HEALTH GUIDE

Health Guide Contacts

Health Guide Ranking
Health Guide Complaints
Utilization Review Requests, Decisions, and Appeals
Health Guide Contacts
Independent External Review
Health Guide

Insurance Company Information

On the following pages you will find specific information on the companies listed in this brochure such as mailing address, the number of insured lives, and customer service phone numbers with hours of operation.

Executive Compensation - For the Maine domestic health insurers (Aetna Health, Anthem Health Plans and CIGNA HealthCare), you will find executive compensation listed for the senior managers and directors. The information is filed with the Bureau of Insurance in accordance with the guidelines of the National Association of Insurance Commissioners. "Insurers that are part of a group of insurers or their holding company system may report amounts paid to officers and employees of more than one insurer in the group or system either on a total gross basis or by allocation to each insurer." CIGNA has listed compensation that appears specific only to the Maine company while the other two companies appear to have listed total compensation for all companies within their group.

Other Financial Information - You may also find extensive financial information by viewing a company's 10K form (annual report) or 10Q form (quarterly report) on the U.S. Securities and Exchange Commission's web-site. The U.S. Securities and Exchange Commission's Electronic Data Gathering, Analysis, and Retrieval (EDGAR) system provides access to compensation and other financial information for publicly traded parent corporations of health insurance carriers. All companies, foreign and domestic, are required to file registration statements, periodic reports, and other forms electronically through EDGAR. Anyone can access and download this information for free. On this web site http://www.sec.gov/edgar.shtml you will find links to a complete list of filings available through EDGAR and instructions for searching the EDGAR database.

Medical Loss Ratios - Included in this brochure are the medical loss ratios by type of health insurance for Maine's domestic health insurers.

General Company Information

Aetna Health, Inc. 175 Running Hill Road, South Portland, ME 04106	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	40,175
Number of covered persons, in **self insured** health insurance plans as of December 31, 2006	7,547
Customer service phone numbers	See ID card
Hours the customer service phone is staffed	8:00 am - 6:00 pm Monday - Friday
Web site	www.Aetna.com
Products offered in Maine	HMO and Point of Service products to large groups. Individuals including sole proprietors are offered an individual HMO health plan.
Accreditation designation	NCQA accreditation

Executive Compensation (the total gross compensation paid to each individual includes all companies which are part of the company group)

Name & Principal Position	**Salary**	**Bonus**	**All Other Compensation**	**Totals**
John W. Rowe M.D., Former Chairman & Chief Executive	$825,000	$2,000,000	$51,061,724	$53,866,724

Officer				
Alan M Bennett, Sr. V.P. & Chief Financial Officer	$568,269	$540,000	$16,925,772	$18,034,041
Timothy A. Holt, Sr. V.P., Investment Management Group	$468,269	$480,000	$13,530,441	$14,478,710
J. Roger Bolton, former Sr. V.P. Communications	$348,077	0	$9,283,664	$9,631,741
William H. Roth, Former Sr. V.P. & Head of Consumer Markets	$47,538	0	$8,826,064	$8,873,602
Elease E. Wright Sr. V.P. Human Resources	$397,308	$304,200	$6,403,603	$7,105,111
Ronald A. Williams, Chairman Chief Executive Officer & President	$1,073,077	$850,000	$4,218,178	$6,141,255
Michael T. Robinson, Head Network Strategy, National Businesses	$233,608	$187,500	$4,248,713	$4,669,821
Craig R. Callen, Sr. V.P. Strategic Planning & Business Development	$611,923	$550,000	$2,906,924	$4,068,847
Ronald M. Olejniczak, V.P. & Controller	$235,461	$103,000	$2,969,245	$3,307,706

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Anthem Health Plans of Maine 2 Gannett Drive, South Portland, ME 04106				
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	252,520			
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	109,474			
Customer service phone numbers	207-822-8282 or 1-800-527-7706			
Hours the customer service phone number is staffed	8:00 am - 5:00 pm Monday - Friday			
Web site	www.anthem.com			
Products offered in Maine	Individual, Small Group, and Large Group, HMO, PPO Point of Service, Medicare Supplement			
Accreditation designation	NCQA accreditation			
Executive Compensation (the total gross compensation paid to each individual includes all companies which are part of the company group)				
Name & Principal	**Salary**	**Bonus**	**All Other**	**Totals**

Position			Compensation	
R. David Kretschmer, Treasurer	$312,500	$287,770	$861,613	$1,461,883
Erin P. Hoeflinger, President & Chairperson	$227,500	$168,021	$247,924	$643,445
Chrystal L. Veazey-Watson, Assistant Secretary	$194,475	0	$210,984	$405,369
Nancy J. Purcell, Secretary	$165,902	$127,949	$103,136	$396,987
Sheila Hanley, Medical Policy Programs Director	$178,001	$76,906	$93,763	$348,670
David T. Hoops, Director State Underwriting	$101,060	$52,824	$147,482	$301,366
Karen E. Andrews, Business Change Director	$135,417	$63,654	$81,627	$280,698
John M. Cooper, Regional Vice President-Sales	$125,867	0	$152,673	$278,540
Lendall L. Smith, Clerk	$125,560	$58,706	$26,096	$210,362

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

CIGNA HealthCare of Maine, Inc. 5 Fundy Road, Suite 300 Falmouth, ME 04105	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	13,526
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	0
Customer service phone number	800-CIGNA24
Hours the customer service phone number is staffed	8:00 am - 5:30 pm Monday - Friday
Web site	www.cigna.com
Products offered in Maine	HMO and Point of Service (POS) plans. Only HMO offered to groups with less than 50 members.
Accreditation designation	NCQA Excellent

Executive Compensation (the total gross compensation paid to each individual is the amount allocated to this insurer only)

Name & Principal Position	Salary	Bonus	All Other Compensation	Totals
Donald Michael Curry, President & Director	$3,656	$5,564	$4,484	$13,704
Aslam M. Khan M.D., V.P. & Director	$4,958	$1,455	$6,067	$12,480

Robert D. Picinich, Vice President	$4,847	$3,765	$2,072	$10,684
Robert P. Hockmuth M.D., Medical Director	$20,285	$5,052	$34,764	$60,101
Sharon W. Heckler, Assistant Secretary	$8,190	$1,452	$4,474	$14,116

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Connecticut General Life Insurance Company 900 Cottage Grove Road, Hartford, CT 06152	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2006	20,292
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	36,748
Customer service phone number	800-CIGNA24
Hours the customer service phone number is staffed	8:00 am - 5:30 pm Monday - Friday
Web site	www.cigna.com
Products offered in Maine	PPO products for large group market: Network Point of Service/Designated Provider Plan, Preferred Provider Plan, Open Access Plus.: CHC Maine Preferred
Accreditation designation	None

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Guardian Life Insurance Company of America 7 Hanover Square, New York, NY 10004	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	30
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	0
Customer service phone number	1-800-873-4542
Hours the customer service phone number is staffed	7:00 am - 8:00 pm (Central Standard Time) Monday - Friday
Web site	www.GuardianLife.com
Products offered in Maine	Guardian Indemnity Insurance - Small and Large Group
Accreditation designation	NCQA for UR management and URAC

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Harvard Pilgrim Health Care, Inc. 93 Worcester Street, Wellesley, MA 02481	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	19,843
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	1,577
Customer service phone number	1-888-333-4742
Hours the customer service phone number is staffed	8:00 am - 7:30 pm Monday & Wednesday

	8:00 am - 5:30 pm Tuesday, Thursday, & Friday
Web site	www.harvardpilgrim.org
Products offered in Maine	Small and Large Group HMO PPO & Point of Service plans, HMO nongroup
Accreditation designation	NCQA Excellent

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

John Alden Life Insurance Company 501 W. Michigan Street, Milwaukee, WI 53203	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	445
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	0
Customer service phone number	1-800-800-1212
Hours the customer service phone number is staffed	7:30 am - 6:30 pm Central Standard Time Monday - Friday
Web site	www.assuranthealth.com
Products offered in Maine	Small Group, Individual, Short-Term Medical
Accreditation designation	URAC

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

MEGA Life & Health Insurance Company 9151 Grapevine Highway, North, Richland Hill, TX 76180	
Number of covered persons in all **fully insured** health insurance or HMO plans issued in Maine as of December 31, 2006	8,277
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	0
Customer service phone number	1-800-527-5504
Hours the customer service phone number is staffed	7:00 am - 7:00 pm Central Standard Time Monday - Friday
Web site	www.megainsurance.com
Products offered in Maine	Small Group Indemnity plans, Large Group
Accreditation designation	N/A (no utilization review)

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Securian Life Insurance Company 400 Robert Street N, St. Paul, MN 55101	
Number of covered persons in all **fully insured** dental plans issued in Maine as of December 31, 2006	13,976
Number of covered persons in **self-insured** dental plans as of December 31, 2006	1,004
Customer service phone number	1-800-234-9009
Hours the customer service phone number is staffed	8:00 am-5:30 pm Monday - Friday
Web site	www.securian.com
Products offered in Maine	Traditional and preferred PPA dental plans to employers

	with two or more eligible employees
Accreditation designation	N/A - Dental coverage only

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Trustmark Life Insurance Company 400 Field Drive, Lake Forest, IL 60045	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2006	496
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	0
Customer service phone number	1-888-813-7099
Hours the customer service phone number is staffed	8:00 am - 9:00 pm Monday - Thursday 8:00 am - 8:00 pm Friday 8:00 am - 2:00 pm Saturday
Web site	www.healthplan.com
Products offered in Maine	Small Group with PPO
Accreditation designation	URAC, NCQA

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

United Healthcare Insurance Company 475 Kilvert St. Suite 310, Warwick, RI 02886	
Number of covered persons in all **fully insured** health insurance plans issued in Maine as of December 31, 2006	1,780
Number of covered persons in **self-insured** health insurance plans as of December 31, 2006	21,170
Customer service phone number	On back of enrollee's insurance card
Hours the customer service phone number is staffed	8:00 am - 8:00 pm Monday - Friday
Web site	www.myuhc.com
Products offered in Maine	Small, Medium, and Large Group (PPO and Point of Service Managed Indemnity plans)
Accreditation designation	URAC

Complaint Ranking Utilization Review Appeals External Reviews Complaints Loss Ratios

Accreditation

What is Accreditation?

A company receives accreditation when they meet specific standards established by the rating organization. Organizations that review health insurers and HMOs for accreditation look at some or all of the following areas: access to care; quality of care; utilization review; customer rights; preventive health services; and the efficiacy, efficiency, appropriateness, availability, timeliness, and continuity of health care. Several organizations perform reviews and have specific accreditation standards. Two of the major accreditation organizations are the National Committee on Quality Assurance (NCQA) and the American Accreditation Healthcare Commission (URAC).

What is NCQA?

NCQA's accreditation program includes selected performance measures in such key areas as member satisfaction, quality of care, and access to needed care with good customer service. To learn more about NCQA accreditation and to get more detailed information about how a plan is rated, visit NCQA's Health Plan Report Card on their web site at *www.ncqa.org*.

What is URAC?

The American Accreditation Healthcare Commission's (URAC) accreditation program is intended to promote quality and accountability for health care organizations. To receive URAC accreditation, managed care organizations must demonstrate quality in both their organizational structure and operations by delivering high quality services to their members in claims review processing, complaints and grievances, and case management. For more information you can visit URAC's web site at www.urac.org.

Loss Ratios by Line for Domestic Health Insurers			
Insurer	**Large Group**	**Small Group**	**Individual**
Aetna Health Inc ME Corp			
Earned premium	$92,387,089	$82,797,704	$87,414
Incurred claims	$73,718,276	$66,794,838	$70,395
Loss Ratio	**80%**	**81%**	**81%**
Anthem Health Plans of ME, Inc.			
Earned premium	$611,202,925	$290,516,248	$94,706,405
Incurred claims	$548,652,721	$230,355,139	$85,467,276
Loss Ratio	**90%**	**79%**	**90%**
Cigna Healthcare of ME, Inc			
Earned premium	$56,101,787	$0	$229,022
Incurred claims	$51,093,503	$0	$174,390
Loss Ratio	**91%**		**76%**

Last Updated: **June 24, 2009**

APPENDIX 2: HEALTH INSURANCE IN MARYLAND

MARTIN O'MALLEY
GOVERNOR

ANTHONY G. BROWN
LIEUTENANT GOVERNOR

MARYLAND
INSURANCE
ADMINISTRATION

RALPH S. TYLER
COMMISSIONER

BETH SAMMIS
KAREN STAKEM HORNIG
DEPUTY COMMISSIONERS

200 St. Paul Place, Suite 2700 Baltimore, Maryland 21202
Direct Dial: 410-468-2000 Fax: 410-468-2020
1-800-492-6116 TTY: 1-800-735-2258
www.mdinsurance.state.md.us

Health Insurance in Maryland: Premiums and Complaints 2007 and 2008

The table below shows information about health insurance in Maryland.

- The names of the largest health insurers, nonprofit health service plans and health maintenance organizations offering insured health benefits to Maryland residents and employers as well as their group affiliation;
- The premium written by each of these companies in 2007 and 2008 as reported by the company to the Maryland Insurance Administration (MIA);[1]
- The loss ratio, a measure of the amount of the premium dollar spent on medical care;
- The number of complaints the MIA closed during the year for each company; and
- The complaint index, a comparative measure of the company's complaints to all companies.

A loss ratio of 80 percent, for example, indicates the company spent 80 cents of every premium dollar collected on medical care. Insurers, nonprofit health service plans and health maintenance organizations offering insured health benefits to individuals must have a loss ratio of at least 60 percent; those offering insured health benefits to small groups must have a loss ratio of at least 75 percent.

The complaint index compares the share of complaints to the share of premiums. It lets you see how a company compares to the average. A complaint index of 1 is average. Less than 1 is better than average. Greater than 1 is worse than average. The MIA included every complaint received from a consumer, provider or other source about a company closed during 2007 and 2008, irrespective of whether the complaint was justified or unjustified. **The complaint index is an indication of dissatisfaction but not of any inappropriate behavior by a company.**

When shopping for health care coverage, there are many things you should consider. These include, but are not limited to:

- The monthly premium;
- The medical services the policy covers and the medical services it excludes;
- Your out-of-pocket costs, such as any copayments, coinsurance, deductibles and your annual limits on out-of-pocket costs (the annual out-of-pocket maximum); and
- For HMOs and preferred provider organizations, the size of the provider network and whether your doctors participate in the HMO or preferred provider organization network.

There is other information available to help you make your selection. You will find a number of publications under Consumers – Publications – General Health Coverage on this website. The Maryland Health Care Commission also has additional information about the performance of HMOs on its website, www.mhcc.md.gov .

[1] Please note the premium reported by the companies is unaudited.

Health Insurance in Maryland: Premiums and Complaints 2007 and 2008											
Company	**2007 Premium**	**% total 2007 Health Benefits Premium**	**2007 Loss Ratio**	**2008 Premium**	**% total 2008 Health Benefits Premium**	**2008 Loss Ratio**	**Closed Complaints 2007**	**Closed Complaints 2008**	**% Change Closed Complaints 2007-2008**	**Complaint Index 2007**	**Complaint Index 2008**
CareFirst	**3,027,940,286**	**50.74%**	**84.12%**	**3,276,318,436**	**53.82%**	**87.38%**	**1,440**	**1,358**	**-5.69%**	**0.62**	**0.56**
CareFirst of Maryland, Inc.	1,250,217,625	20.95%	88.44%	1,308,177,094	21.49%	92.24%	788	635	-19.42%	0.82	0.65
Group Hospitalization and Medical Services, Inc.	587,695,635	9.85%	83.05%	671,161,933	11.02%	83.91%	274	311	13.50%	0.61	0.62
CareFirst BlueChoice, Inc.	1,190,027,026	19.94%	80.69%	1,296,979,409	21.30%	84.27%	378	412	8.99%	0.41	0.43
Aetna	**835,610,312**	**14.00%**	**79.42%**	**945,175,583**	**15.53%**	**79.47%**	**529**	**422**	**-20.23%**	**0.82**	**0.60**
Aetna Life Insurance Company (Insurer)	104,353,959	1.75%	75.72%	127,265,781	2.09%	71.62%	314	247	-21.34%	3.91	2.61
Aetna Health Inc. (HMO)	731,256,353	12.25%	79.95%	817,909,802	13.44%	80.96%	215	175	-18.60%	0.38	0.29
Coventry	**207,382,934**	**3.48%**	**84.73%**	**205,631,812**	**3.38%**	**84.70%**	**121**	**102**	**-15.70%**	**0.76**	**0.67**
Coventry Health & Life Ins. Co. (Insurer)	5,334,029	0.09%	86.30%	7,438,139	0.12%	97.16%	2	1	-50.00%	0.49	0.18
Coventry Health Care of DE, Inc. (HMO)	202,048,905	3.39%	84.69%	198,193,673	3.26%	84.23%	119	101	-15.13%	0.76	0.69
Cigna	**133,282,593**	**2.23%**	**73.50%**	**115,683,902**	**1.90%**	**77.94%**	**103**	**131**	**27.18%**	**1.00**	**1.52**
Connecticut General Life Ins. Co. (Insurer)	109,029,241	1.83%	71.99%	112,142,853	1.84%	78.03%	88	116	31.82%	1.05	1.39
Cigna Healthcare Mid., Inc. (HMO)	24,253,352	0.41%	80.32%	3,541,049	0.06%	75.13%	15	15	0.00%	0.80	5.70
UnitedHealthcare	**946,621,936**	**15.86%**	**78.48%**	**834,632,845**	**13.71%**	**80.27%**	**1058**	**1,090**	**3.02%**	**1.45**	**1.76**
Optimum Choice	473,116,657	7.93%	80.14%	328,573,377	5.40%	80.07%	457	439	-3.94%	1.25	1.80
M.D. IPA	14,477,397	0.24%	79.34%	23,502,268	0.39%	130.07%	137	182	32.85%	12.29	10.42
MAMSI Life & Health Insurance Co., Inc.	210,488,643	3.53%	75.32%	122,442,014	2.01%	73.57%	184	150	-18.48%	1.14	1.65
UnitedHealthcare Insurance Co.	182,628,284	3.06%	80.96%	250,624,317	4.12%	79.80%	187	213	13.90%	1.33	1.14
UnitedHealthcare of Mid-Atlantic	41,514,175	0.70%	84.16%	80,589,995	1.32%	89.62%	77	81	5.19%	2.41	1.35
Golden Rule	24,396,780	0.41%	44.63%	28,900,874	0.47%	48.49%	16	25	56.25%	0.85	1.16
Kaiser	**498,455,834**	**8.35%**	**88.70%**	**494,703,438**	**8.13%**	**86.30%**	**119**	**147**	**23.53%**	**0.31**	**0.40**
Subtotal Largest Writers	5,649,293,895	94.67%	82.61%	5,872,146,016	96.46%	84.80%	3,370	3,250	-3.56%	0.77	0.74
Total All Health Benefits	**5,967,426,222**	**100.00%**	**82.18%**	**6,087,701,409**	**100.00%**	**84.17%**	**4,596**	**4,524**	**-1.57%**	**1.00**	**1.00**

APPENDIX 3: MINNESOTA REPORT OF 2008 LOSS RATIO

Report of 2008 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies Nonprofit Health Service Plan Corporations and Health Maintenance Organizations

June, 2009

Rev. 8/01/2009

Table of Contents

Introduction

Under Minnesota Statutes, section 62A.021, subdivision 1(h), the Minnesota Departments of Health and Commerce are required to issue a public report each year listing, by health plan company, the actual loss ratios experienced in the individual and small employer markets in the State of Minnesota. This report includes loss ratios for the calendar year ending December 31, 2008, for health plan companies regulated by the Minnesota Departments of Health and Commerce. There is a public interest in dissemination of information that may help consumers to choose from among available health plan companies.

The loss ratio is a rough measure of how much of the premium revenue was spent on medical care. Revenue not used to pay medical expenses is used for health plan administration, marketing, taxes, other expenses, and net income. In reality, due to many reasons related to operation and measurement, loss ratios are not necessarily an indicator of value for a specific health plan company in any one year.

State law has established some minimum loss ratios for small group and individual plans to ensure a minimum value to the consumer. See page 6 for a description of the requirements.

Roughly 8 percent of the population receives coverage through a small group, while 5 percent of the population purchases individual coverage. Of the remainder, 54 percent of the population receives coverage through a large group, 25 percent receives coverage through public programs, and 7 percent is uninsured. These numbers do not total 100% due to rounding.

Claim cost levels have continued to increase for most health plan companies, leading to a series of high rate increases for small employer and individual health plans. Most large employers have self-insured plans, which allow them to reduce cost while having more control over their employee benefits. Self-insured plans are not subject to state benefit mandates or state premium taxes and assessments. This option is not generally available to small employers, because they do not usually have the financial resources to accept the risk of large claims.

Definition of Loss Ratio

The loss ratio is the ratio of incurred claims to earned premiums. Health plan companies were asked to provide the total earned premium, incurred claims, and loss ratio for the year ending December 31, 2008, separately for the individual and small employer health plan markets. The small employer market includes non-compliant small employer plans that have been treated as part of the small employer block of business. The small employer market does not include employers with 51 or more employees, even if fewer than 51 employees from a group have enrolled for health plan coverage.

The individual market includes individual policies issued as conversions from group health plan coverage. However, if a company has conversion policies in force, but no other individual health plan business, it need not report data for the individual market.

Earned Premium

Earned premium is premium earned during 2008, without adjusting for any payments to the Minnesota Health Care Reinsurance Association (MHCRA) or private reinsurance arrangements. Earned premiums are equal to paid premium for the year plus uncollected premiums minus premiums paid in advance.

Earned premium should be based on the most recent available estimates of the premium-related accrual amounts. The number includes any fees from policyholders such as enrollment fees, monthly fees, or processing fees. The number should be calculated without subtracting any commissions or marketing expenses from the premiums. Premiums do not include any payments for Administrative Services Only contracts or any fee-for-service income that was given on a non-insured basis to medical care providers.

Incurred Claims for Insurance Companies and Nonprofit Health Service Plan Corporations

Incurred claims include the paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other reserves held, plus the expenses incurred during the year for the following items, where expenses for a functional area should include allocated costs such as electronic data processing equipment, office space, management, overhead, and so on:

- Any accrued expected value of withholds, bonuses, or other amounts to be paid to providers under contracts with the health plan company
- Any accrued prescription drug rebates or refunds from pharmaceutical companies (a reduction to the claims)
- Case management activities
- Capitations paid or accrued to providers for claims incurred during 2008

- Clinical quality assurance and other types of medical care quality improvement efforts
- Concurrent or prospective utilization review as defined in Minnesota Statutes, section 62M.02, subdivision 20
- Consumer education solely for health improvement
- Detection and prevention of payment for fraudulent requests for reimbursement
- Net reinsurance cost (premiums less claims) for the MHCRA and private reinsurance, and assessments by MHCRA
- Network access fees to Preferred Provider Organizations and other network-based health plans
- Provider contracting and credentialing costs
- Provider tax required by Minnesota Statutes, section 295.52

Incurred Claims for Health Maintenance Organizations

Incurred claims include the paid-on-incurred claims for the year, plus a reserve for claims incurred but not yet paid, plus the change in any other reserves held, plus the expenses incurred during the year for the following items, where expenses for a functional area should include allocated costs such as electronic data processing equipment, office space, management, overhead, and so on.

The following are also included as incurred claims for health maintenance organizations:

- The 0.6% Medicaid surcharge paid by health maintenance organizations
- Any accrued expected value of withholds, bonuses, or other amounts to be paid to providers under contracts with the health maintenance organization
- Any accrued prescription drug rebates or refunds from pharmaceutical companies (a reduction to the claims)
- Case management activities involving direct patient care
- Capitations paid or accrued to providers for claims incurred during 2008
- Consumer education solely for health improvement involving direct patient care
- Net reinsurance cost (premiums less claims) for private reinsurance.
- Provider tax required by Minnesota law

The following are not included as incurred claims for health maintenance organizations:

- Concurrent or prospective utilization review as defined in Minnesota Statutes, section 62M.02, subdivision 20
- Provider contracting and credentialing costs
- Detection and prevention of payment for fraudulent requests for reimbursement

- Clinical quality assurance and other types of medical care quality improvement efforts
- Network access fees to Preferred Provider Organizations and other network-based health plans

Notes on Using the Results

How to Use the Data

In order to use the loss ratio data for a specific purpose, it is important to find out additional information relevant to that purpose. As discussed below, loss ratios may not be a good way to compare health plan companies, unless other information is taken into account.

For example, when the Commerce Department reviews health plan rates for compliance with statutory requirements, we ask for additional information to evaluate the rates, including:

- how the loss ratio has been calculated
- the benefits that will be offered
- any recent changes in rates or benefits
- national experience when Minnesota experience is not very credible
- an analysis of the relative newness of the experience
- any other information that will help evaluate whether rates will meet the statutory requirements

Unintentional Errors

The earned premiums, incurred claims, cost containment expenses, and loss ratios that are listed in this report have been provided by the health plan companies. We have not independently verified the loss ratios, and even the most careful process will sometimes include unintentional errors.

Calculation Methods

There are different ways of calculating a loss ratio, depending on the accounting method used for calculating earned premiums and incurred claims. One method is used for the statutory annual financial statement, and includes estimates of premiums and claims that have not yet been recorded, and also includes changes in the estimates for the previous year. Another method is commonly used for setting and filing rates. This method restates the earned premium and incurred claims using the most recent information, and does not incorporate adjustments from previous periods. For this report, we have asked the health plan companies to provide loss ratios using the second method.

Loss Ratio is not the Same as Value

The loss ratio can be a good measure of relative value if two health plan companies are very similar in the benefits they provide and other factors. In that case, the plan with the higher loss ratio would be a better value.

However, health plan companies differ in a variety of ways, and therefore the relative loss ratio is not always indicative of relative value. For example, one health plan company may not spend much effort preventing payment of fraudulent claims, while another may spend much more time and money, resulting in non-payment of many fraudulent claims. The first company would have a higher loss ratio due to the fraudulent claims it paid, but that would not be a value to the honest policyholders. Similarly, one health plan company may pay doctors and hospitals at a higher charge level than another, due to different contractual arrangements. Those higher payments do not represent greater value to the policyholder.

Also, every prospective policyholder is different, with different needs for health care. In order to compare health plan companies, it is necessary to review other aspects of the company affecting value, such as availability of particular medical care providers, quality of patient service, and quality of care management.

Statistical Fluctuation

Loss ratios also are subject to statistical fluctuation. Each individual's health care costs are more or less unpredictable, and the total incurred claims of a health plan company are also more or less unpredictable. Having a high or low loss ratio may have been due to such fluctuations, and may not be repeated in a future time period.

Recent Changes

Any change that has been made in a health plan company's business since the beginning of the reporting period also affects the loss ratio. For example, the rate levels or benefits offered may have changed significantly, due to legislative requirements or improvements offered by the health plan company.

Newness of Coverage

The newness of the health plans also has an effect on the loss ratio. Policies that have been recently sold typically have lower levels of claims than policies that have been in force for a year or more. Thus, a health plan company may have a relatively low loss ratio, due to a large proportion of relatively new policies, but its expected future loss ratio may not be low.

How Rates are Regulated

Minnesota Statutes, section 62A.02, requires all health plan rates to be approved by the Commissioner of Commerce or the Commissioner of Health before being used. The health plan company must supply actuarial reasons and data demonstrating that the benefits are reasonable in relation to the premiums. The Departments of Commerce and Health review all rates to verify reasonableness and compliance with other statutory limitations such as rate bands. Rate restrictions for small employer plans are specified in Minnesota Statutes, section 62L.08, and for individual plans are specified in Minnesota Statutes, section 62A.65.

Loss Ratio Standards

In addition to being reasonable and meeting rate restrictions, individual and small employer health plan rates must be calculated to meet the specific minimum loss ratio standards in Minnesota Statutes, section 62A.021. For health maintenance organizations and nonprofit health service plan corporations, Minnesota law requires that small employer group plans have rates that are set to achieve a minimum loss ratio of 71% to 82%, and that individual plans have rates that are set to achieve a minimum loss ratio of 68% to 72%.

Health maintenance organizations and nonprofit health service plan corporations have different minimum loss ratios based upon whether they are assessed less than 3% of the total annual amount assessed by the Minnesota Comprehensive Health Association (MCHA). The loss ratio requirements are:

Individual coverage:

- 72% for companies assessed 3% or more of the total annual MCHA assessment
- 68% for companies assessed less than 3% of the total annual MCHA assessment

Small employer coverage:

- 82% for companies assessed 3% or more of the total annual MCHA assessment
- 71% for companies assessed less than 3% of the total annual MCHA assessment, on their policies with fewer than 10 employees
- 75% for companies assessed less than 3% of the total annual MCHA assessment, on their policies with 10 or more employees

For insurance companies, Minnesota law requires that small employer group plans and individual plans have rates that are set to achieve a minimum loss ratio of 60%. For insurance companies (including affiliates) that are assessed 10% or more of the total annual MCHA assessment, the loss ratio standards used are the same as those used for health maintenance organizations and nonprofit health service plan corporations. Currently, only Medica Insurance Company and HealthPartners Insurance Company fall into this category.

Individual Health Plan Loss Ratios

Attachments 1 and 2 list the loss ratios experienced in the individual health plan market in 2008 by health plan companies that cover individuals in that market. Not all health plan companies with individual health plans in force are included, as some had premium volume lower than $200,000, which we considered too low to include. Attachment 1 contains a list in order by decreasing premium volume of the health plan companies that responded. Attachment 2 contains an alphabetical list of the same health plan companies.

The loss ratios for 2008 for health plan companies ranged from 44% to 132%. The total loss ratio for 2008 for health plan companies is 92%, higher than the 91% total loss ratio from last year.

The lowest loss ratios are usually on small, non-credible blocks of business. The highest loss ratios are usually on blocks of business that are primarily polices or certificates of coverage used as the mandated portability option required by Minnesota Statutes, section 62A.65, subdivision 5(b), for persons formerly covered in group health plans who have exhausted the mandated continuation coverage.

Small Employer Health Plan Loss Ratios

Any person, firm, corporation, partnership, association or other entity actively engaged in business (including political subdivisions of the state) is considered a small employer group if:

- it employed 2-50 workers who worked at least 20 hours per week on business days during the preceding calendar year; and
- it employs at least 2 current employees on the first day of the health plan year.

Attachments 3 and 4 list the loss ratios experienced in the small employer health plan market in 2008 by health plan companies that cover small employer groups. Attachment 3 contains a list in order by decreasing premium volume of the health plan companies that responded. Attachment 4 contains an alphabetical list of the same health plan companies.

The loss ratios for 2008 for health plan companies ranged from 66% to 138%. The total loss ratio for 2008 for health plan companies is 87%, the same as the 87% total loss ratio from last year.

Health Care Cost Containment in Minnesota

Minnesota Statutes, section 62J.015

The legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health care coverage for our insured residents is increasing annually at a rate that far exceeds the state's overall rate of inflation.

The legislature further finds that it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

The legislature further finds that controlling costs is essential to the maintenance of the many factors contributing to the quality of life in Minnesota: our environment, education system, safe communities, affordable housing, provision of food, economic vitality, purchasing power, and stable population.

It is, therefore, the intent of the legislature to lay a new foundation for the delivery and financing of health care in Minnesota and to call this new foundation the MinnesotaCare Act.

Calculation Method

The cost containment expense listed in this report is for Minnesota specific experience, and was obtained from the health plan companies. We have not independently verified the cost containment expense amounts submitted by the health plan companies. Cost containment expense is defined in the Statement of Statutory Accounting Principle (SSAP) No. 85 as, expenses that actually serve to reduce the number of health services provided or cost of such services. The following are examples of items listed in SSAP No. 85 that shall be considered "cost containment expenses" only if they result in reduced levels of costs or services:

- Case management activities;
- Utilization review;
- Detection and prevention of payment for fraudulent requests for reimbursement;
- Network access fees to preferred Provider Organizations and other network-based health plans, and allocated internal salaries and related costs associated with network development and/or contracting;
- Consumer education solely relating to health improvement and relying on the direct involvement of health personnel, such as smoking cessation and disease management programs; and
- Expenses for internal and external appeals processes.

Individual Cost Containment Expense

Attachment 5 lists the cost containment expense incurred in the individual health plan market in 2008 by health plan companies that cover individuals in that market. Not all health plan companies with individual health plans in force are included, as some had premium volume lower than $200,000, which we considered too low to include. Attachment 5 contains an alphabetical list of the health plan companies that responded.

The cost containment expense for 2008 for health plan companies ranged from 0% to 4% of premiums earned in the individual market. The total cost containment expense for 2008 for health plan companies is 2%.

Small Employer Cost Containment Expense

Attachment 6 lists the cost containment expense incurred in the small employer health plan market in 2008 by health plan companies that cover small employer groups. Not all health plan companies with small employer group health plans in force are included, as some had premium volume lower than $200,000, which we considered too low to include. Attachment 6 contains an alphabetical list of the health plan companies that responded.

The cost containment expense for 2008 for health plan companies ranged from 0% to 2% of premiums earned in the small employer group market. The total cost containment expense for 2008 for health plan companies is 1%.

Additional Reference Sources

For information about insurance companies and nonprofit health service plan corporations

Minnesota Department of Commerce
Enforcement Division
85 Seventh Place East, Suite 500
St Paul, MN 55101-2198
(651) 296-2488; (800) 657-3602
www.insurance.mn.gov

For information about health maintenance organizations

Minnesota Department of Health
Managed Care Systems Section
85 Seventh Place East
P.O. Box 64882
St. Paul, MN 55164-0882
(651) 201-5100; (800) 657-3916
www.health.state.mn.us/hmo

For information about this report, contact Melane Milbert at (651) 282-5605.
melane.milbert@state.mn.us

Attachment 1

Premium Order List for Individual

Company	2008 Premiums	2008 Claims	Loss Ratio
** BCBSM, Inc.	$ 416,157,949	$ 384,185,661	92%
Time Insurance Company	$ 51,443,649	$ 44,310,359	86%
* HealthPartners	$ 31,590,469	$ 31,301,971	99%
HealthPartners Insurance Company	$ 26,365,611	$ 16,914,937	64%
Medica Insurance Company	$ 25,355,420	$ 25,025,180	99%
* Medica	$ 12,096,479	$ 14,875,152	123%
American Family Mutual Insurance Company	$ 9,237,649	$ 7,163,880	78%
World Insurance Company	$ 8,003,773	$ 8,041,596	100%
State Farm Mutual Automobile Insurance Company	$ 5,751,231	$ 7,151,820	124%
John Alden Life Insurance Company	$ 3,618,140	$ 3,082,903	85%
PreferredOne Insurance Company	$ 2,216,773	$ 1,045,009	47%
Golden Rule Insurance Company	$ 2,151,756	$ 1,937,568	90%
Principal Life Insurance Company	$ 1,000,637	$ 1,322,433	132%
Thrivent Financial for Lutherans	$ 319,446	$ 139,815	44%
Total	$ 595,308,982	$ 546,498,284	92%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

Attachment 2

Alphabetic List for Individual

Company	2008 Premiums	2008 Claims	Loss Ratio
American Family Mutual Insurance Company	$ 9,237,649	$ 7,163,880	78%
** BCBSM, Inc.	$ 416,157,949	$ 384,185,661	92%
Golden Rule Insurance Company	$ 2,151,756	$ 1,937,568	90%
* HealthPartners	$ 31,590,469	$ 31,301,971	99%
HealthPartners Insurance Company	$ 26,365,611	$ 16,914,937	64%
John Alden Life Insurance Company	$ 3,618,140	$ 3,082,903	85%
* Medica	$ 12,096,479	$ 14,875,152	123%
Medica Insurance Company	$ 25,355,420	$ 25,025,180	99%
PreferredOne Insurance Company	$ 2,216,773	$ 1,045,009	47%
Principal Life Insurance Company	$ 1,000,637	$ 1,322,433	132%
State Farm Mutual Automobile Insurance Company	$ 5,751,231	$ 7,151,820	124%
Thrivent Financial for Lutherans	$ 319,446	$ 139,815	44%
Time Insurance Company	$ 51,443,649	$ 44,310,359	86%
World Insurance Company	$ 8,003,773	$ 8,041,596	100%
Total	$ 595,308,982	$ 546,498,284	92%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

Attachment 3

Premium Order List for Small Employer

Company	2008 Premiums	2008 Claims	Loss Ratio
** BCBSM, Inc.	$ 653,722,304	$ 575,861,930	88%
Medica Insurance Company	$ 420,079,849	$ 365,607,299	87%
* HealthPartners	$ 278,518,347	$ 235,252,391	84%
Federated Mutual Insurance Company	$ 49,392,832	$ 38,008,412	77%
* Blue Plus	$ 48,759,855	$ 41,201,622	84%
* PreferredOne Community Health Plan	$ 47,807,129	$ 41,005,321	86%
HealthPartners Insurance Company	$ 27,331,492	$ 24,499,173	90%
Principal Life Insurance Company	$ 3,318,219	$ 2,182,137	66%
* First Plan of Minnesota	$ 3,182,079	$ 2,370,060	74%
Time Insurance Company	$ 3,135,076	$ 4,315,288	138%
John Alden Life Insurance Company	$ 2,272,757	$ 2,386,327	105%
PreferredOne Insurance Company	$ 2,049,719	$ 1,621,953	79%
Noridian Mutual Insurance Company	$ 1,907,774	$ 1,869,102	98%
Sanford Health Plan	$ 314,961	$ 228,064	72%
Union Security Insurance Company	$ 296,327	$ 205,685	69%
Total	$ 1,542,088,720	$ 1,336,614,764	87%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

Attachment 4

Alphabetic List for Small Employer

Company	2008 Premiums	2008 Claims	Loss Ratio
** BCBSM, Inc.	$ 653,722,304	$ 575,861,930	88%
* Blue Plus	$ 48,759,855	$ 41,201,622	84%
Federated Mutual Insurance Company	$ 49,392,832	$ 38,008,412	77%
* First Plan of Minnesota	$ 3,182,079	$ 2,370,060	74%
* HealthPartners	$ 278,518,347	$ 235,252,391	84%
HealthPartners Insurance Company	$ 27,331,492	$ 24,499,173	90%
John Alden Life Insurance Company	$ 2,272,757	$ 2,386,327	105%
Medica Insurance Company	$ 420,079,849	$ 365,607,299	87%
Noridian Mutual Insurance Company	$ 1,907,774	$ 1,869,102	98%
* PreferredOne Community Health Plan	$ 47,807,129	$ 41,005,321	86%
PreferredOne Insurance Company	$ 2,049,719	$ 1,621,953	79%
Principal Life Insurance Company	$ 3,318,219	$ 2,182,137	66%
Sanford Health Plan	$ 314,961	$ 228,064	72%
Time Insurance Company	$ 3,135,076	$ 4,315,288	138%
Union Security Insurance Company	$ 296,327	$ 205,685	69%
Total	$ 1,542,088,720	$ 1,336,614,764	87%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

Attachment 5

2008 Cost Containment Expense for Individual

Company	Premiums Earned	Cost Containment Expense	Percent of Premiums
American Family Mutual Insurance Company	$ 9,237,649	$ 301,464	3%
** BCBSM, Inc.	$ 416,157,949	$ 8,992,000	2%
Golden Rule Insurance Company	$ 2,151,756	$ 27,973	1%
* HealthPartners	$ 31,590,469	$ 254,000	1%
HealthPartners Insurance Company	$ 26,365,611	$ 239,000	1%
John Alden Life Insurance Company	$ 3,618,140	$ 1,741	0%
* Medica	$ 12,096,479	$ 21,329	0%
Medica Insurance Company	$ 25,355,420	$ 207,899	1%
PreferredOne Insurance Company	$ 2,216,773	$ 6,941	0%
Principal Life Insurance Company	$ 1,000,637	$ 2,602	0%
State Farm Mutual Automobile Insurance Co	$ 5,751,231	$ 88,802	2%
Thrivent Financial for Lutherans	$ 319,446	$ -	0%
Time Insurance Company	$ 51,443,649	$ 95,064	0%
World Insurance Company	$ 8,003,773	$ 307,400	4%
Total	$ 595,308,982	$ 10,546,215	2%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

Attachment 6

2008 Cost Containment Expense for Small Employer

Company	Premiums Earned	Cost Containment Expense	Percent of Premiums
** BCBSM, Inc.	$ 653,722,304	$ 10,310,000	2%
* Blue Plus	$ 48,759,855	$ 643,000	1%
Federated Mutual Insurance Company	$ 49,392,832	$ 840,492	2%
* First Plan of Minnesota	$ 3,182,079	$ 49,507	2%
* HealthPartners	$ 278,518,347	$ 2,327,000	1%
HealthPartners Insurance Company	$ 27,331,492	$ 281,000	1%
John Alden Life Insurance Company	$ 2,272,757	$ 1,080	0%
Medica Insurance Company	$ 420,079,849	$ 3,444,402	1%
Noridian Mutual Insurance Company	$ 1,907,774	$ 42,220	2%
* PreferredOne Community Health Plan	$ 47,807,129	$ 368,405	1%
PreferredOne Insurance Company	$ 2,049,719	$ 3,727	0%
Principal Life Insurance Company	$ 3,318,219	$ 8,627	0%
Sanford Health Plan	$ 314,961	$ 3,177	1%
Time Insurance Company	$ 3,135,076	$ 6,405	0%
Union Security Insurance Company	$ 296,327	$ 849	0%
Total	$ 1,542,088,720	$ 18,329,891	1%

* Health Maintenance Organization (HMO)
** Nonprofit Health Service Plan Corporation

APPENDIX 4: NEW JERSEY COMMERCIAL HEALTH MARKET

NJ Commercial Health Market - 2006

Prepared by
Life & Health
New Jersey Dept. of Banking and Insurance
7/1/2009

The New Jersey Commercial Health Market

The commercial health market, as described in this report, consists of comprehensive (medical and hospital) coverage that is issued by a regulated carrier (insurer, health service corporation, or HMO) in New Jersey and subject to New Jersey DOBI regulation. *(1)*

The commercial health market does not include self-funded coverage provided by larger corporations, labor unions, or governments. It also does not include government programs such as Medicare, Medicaid, or coverage for military or civilian Federal employees, or private coverage such as Medicare Supplement and Medicare Advantage which supplements or is an alternative to traditional Medicare. It does not include student coverage provided at colleges, universities, and other schools. It also does not include coverages such as dental, disability income, or long term care.

The regulated commercial market (large group, small group, and individual) covered approximately 2.5 million people with total premium of $8.95 billion in 2005. Total claims paid were $7.31 billion, for a medical loss ratio of 81.7%. As discussed below, the loss ratio varies by market segment and carrier.

The three largest carriers in the New Jersey commercial market are Horizon, Aetna, and United/Oxford. Of the 2.5 million insured, Horizon covers about 850,000, (about one-third), Aetna covers about 650,000 (about one-fourth), and United Oxford about 470,000 (about one fifth). AmeriHealth, Health Net, and CIGNA each have between 5% and 7% of the market and no other carrier has more than 1% of the market. Market share varies by market segment and location.

The Department estimates that, in 2005, the 5 largest carriers had combined underwriting gains, in the commercial market only, of approximately $315 million, or 4.0% of commercial premium. There was variation among carriers, but the average gain as a percentage of premium was 4.7% for large group, 3.2% for small group, and 1.4% for individual. These estimated profit margins do not include the impact of investment gains or federal income tax, nor do they include gains or losses on other lines of business such as Medicaid, Medicare Supplement or Medicare Advantage.

(1) Most people covered in the NJ commercial market are NJ residents. However, some non-NJ residents who work in NJ are covered by NJ contracts issued to their employers. Conversely, some NJ residents who work in other states are covered by non-NJ contracts.

Source of Coverage

Attachment 1, Source of Coverage, summarizes the source of health coverage for the people of New Jersey.Approximately 2.1 million people (25 % of the population) have their coverage through the regulated health coverage market. (This is less than the 2.4 million mentioned because it excludes older employees and retirees who are also eligible for Medicare and for whom Medicare is the listed source in Attachment 1.) Of this 2.1 million, approximately 903,000 had coverage through the SEH (small employer market) and another 83,000 through the individual market, with the rest receiving coverage through large employers, student coverage, self-funded MEWAs (multiple employer self-funded arrangements) or other groups. Another 2.3 million (26%) are estimated to receive self-funded coverage from private employer or union plans. 3 million (34%) have coverage from government plans, including Medicare, Medicaid, SHBP, or FEHBP. (Insured and uninsured local government plans not part of the SHBP are included in the private market figures.) Over 1.3 million people (15%) were without coverage.

The Source of Coverage estimate must be taken as a rough approximation. It is prepared from many sources with different reporting dates, and is subject to misreporting of status, inconsistent treatment of out-of-state residents or contracts, and double-counting from multiple sources of coverage. However, it provides a useful overview of the number of people covered by the major programs.

Market Share

Attachment 2, Market Share, measures concentration in the commercial health market. Market share can be measured as a percentage of enrollment or a percentage of premium, and both are shown in the attachment. This report generally uses percentage of enrollment. Because the three market segments (large group, small group, and individual) are different, market share by segment is more meaningful than overall market share. Market share is shown on an affiliated basis; affiliated companies generally offer complementary products. This report ignores the smallest carriers in the market, as well as carriers covering only college and other students.

As noted above, the commercial market covered 2.4 million people with premiums of $9.15 billion in 2006. The three largest carriers (with market share by enrollment) were Horizon (40.4%), Aetna (24.3%) and United/Oxford (17.0%). The next three largest carriers AmeriHealth, CIGNA, and Health Net, all have market share between 4% and 7%. The remaining carriers all have market share less than 1%.

Horizon is the largest carrier in the large group segment with 45.8% (38.5% in 2005), followed by Aetna with 18.4% (19.1% in 2005) and Oxford/United with 15.2% (19.0% in 2005). The next largest carriers in this segment were CIGNA (8.7%) and AmeriHealth (6.8) %. Many groups in this market are partially or fully experience rated; their rates depend on the groups' actual claims experience. Such groups, especially the larger ones, may have the option of self-funding and removing themselves from the regulated commercial market.

In the small group segment, Aetna at 35.0% (39.3% in 2005), Horizon at 30.6% (25.5% in 2005), United/Oxford 18. % (18.5% in 2005) are the three largest carriers. Health Net and AmeriHealth (7.0%) and Health Net (6.8%) are the next largest carriers.

The four largest carriers in the individual market are Horizon (60.2%), United/Oxford (23.1%), Aetna (9.4%), and AmeriHealth (5.3%). The IHC market includes Indemnity Plans (almost all Horizon), Managed Care (HMO and PPO) and Basic and Essential (B&E) plans. The structure of the IHC market has changed since 2004 due to the introduction of B&E plans with riders, leading to increasing enrollment in the B&E segment.

Loss Ratio

Attachment 3, Loss Ratios shows the ratio of provider claims incurred to premiums earned. Provider claims do not include claims administration expenses or expenses associated with loss control (such as utilization management). The medical loss ratio measures accuracy of pricing and efficiency. The complement of the loss ratio (100% - the loss ratio) is the percentage of premiums required to administer the system, including claim processing, producer commissions, taxes, and profits. Loss ratios are calculated on a carrier (rather than affiliated company) basis.

The average loss ratio for the commercial market is around 80%. In recent years, it has gradually increased from just below 80% to above 80%. The 81.5 % loss ratio in 2006 was almost the same as the 81.7% loss ratio in 2005 and a bit lower than the 82.5% average for 2004. There is considerable variation among carriers and markets, with some carriers falling below the 75% minimum in the SEH or IHC markets. In the case of those two markets, refunds are required to bring the loss ratio to 75%.

The 2005 average loss ratio in the large group segment was 81.3%. Among the 10 largest carriers by premium volume, the loss ratio ranged from a low of 72.1% to a high of 89.8%. This variation is based largely on two things - variation among companies in target loss ratio (the loss ratio they hope to achieve, considering administrative costs and intended profit) and variation among companies in actual experience.

The average loss ratio in the small group market was 81.8%. (up slightly from 81.4% in 2005). Among the 10 largest carriers, loss ratios ranged from a low of 75% (including refunds) to a high of 90.2%.

The average loss ratio is the individual market was 81.9%, down significantly from the 85.1% in 2005 and similar to 81.8% in 2004. (Some of the smallest companies were excluded from the study). In the individual market, loss ratios of the larger companies ranged from 75.9% to 108.5%. There are several reasons for the greater variation in loss ratios in the Individual Market, including generally smaller groups of covered lives, and the impact of individual selection in a guaranteed insurability market.

Average Premiums

Based on the premium and enrollment in the market share report, the average premium per covered person in the commercial market was $3,813 or $318 per month. Remember that this does not reflect the entire of cost covered medical care, because, in addition to the premium, the covered person is responsible for deductibles, coinsurance, and copayments. Also, dependent children are included in this average. Their costs tend to be lower than average, so this premium should not be seen as the average cost of insuring a single adult (perhaps 30% higher in the commercial market).

The average was $3,781 ($315 a month) in the large group market and $3,759 ($313 a month) in the small group market. This does not necessarily say that the markets are similar in cost, because small group contracts may have more cost-sharing, so a lower level of insured benefit, than large group. (Small group also has a larger percentage of closed panel HMO coverage, which tends to be less expensive than coverage providing for out of network benefits.) The average premium in the individual market is $5,043 ($420 a month) $4,744, which reflects the high average age and adverse selection of this market.

Conclusion

The Department monitors source of coverage, market share, loss ratios, and average premiums in the commercial market. In addition, we monitor underwriting profits. Along with total enrollment, average premium, and premium increases, these are measures of the performance of the commercial insurance system.

ATTACHMENT 3
COMMERCIAL LOSS RATIO
2006

9/1/2009	2006	PAGE 30.NJ	Comprehensive	Comprehensive	Comprehensive			Large Group	Large Group
	NAIC	Company	Premiums	Claims	Loss Ratio			Premiums	Claims
2006	55069	Horizon Healthcare Svcs (BCBS)	$3,294,927,039	$2,800,593,665	85.0%			$2,405,985,057	$2,053,578,704
2006	95287	Aetna Health (NJ)	$2,052,252,502	$1,626,141,533	79.2%			$884,044,360	$651,890,291
2006	78026	Oxford Health Ins	$883,475,469	$686,963,050	77.8%			$403,728,595	$305,724,738
2006	95529	Horizon Healthcare of NJ (HMO)	$554,019,215	$415,838,892	75.1%			$171,981,666	$123,917,164
2006	95506	Oxford Health Plan of NJ	$439,570,508	$329,682,834	75.0%			$176,545,449	$129,086,162
2006	95351	Health Net of NJ	$429,781,100	$339,320,989	79.0%			$182,751,800	$147,004,055
2006	95044	Amerihealth HMO	$382,262,782	$334,978,186	87.6%			$193,958,384	$174,196,343
2006	62308	Conn Gen Life Ins Co	$356,704,489	$299,203,677	83.9%			$339,141,217	$285,999,733
2006	60061	Amerihealth Ins Co of NJ	$224,593,118	$191,001,500	85.0%			$149,492,008	$123,299,782
2006	79413	United HealthCare Ins Co	$202,368,642	$173,617,064	85.8%			$199,859,133	$171,843,085
2006	95500	CIGNA Health Care of NJ	$149,122,038	$126,792,311	85.0%			$106,781,295	$89,151,661
2006	60054	Aetna Life Ins. Co	$75,515,927	$44,741,780	59.2%			$66,604,900	$36,976,103
2006	64246	Guardian Life Ins Co of Amer	$36,916,988	$26,961,334	73.0%			$27,525,752	$17,687,992
2006	95433	Wellchoice HMO of NJ	$30,199,292	$24,215,198	80.2%			$17,090,545	$14,075,057
2006	80314	Unicare	$13,413,937	$12,880,973	96.0%			$13,413,937	$12,880,973
2006	81264	Nippon Life	$12,189,097	$11,256,960	92.4%			$8,363,909	$8,388,069
2006	62863	Trustmark Life	$5,299,746	$5,220,991	98.5%			$2,411,024	$1,934,356
2006	61705	Wellchoice Ins Co of NJ	$4,911,726	$4,190,599	85.3%			$2,779,546	$1,994,508
2006	80926	Genworth (GE Group Life)	$4,814,716	$4,076,138	84.7%			$4,814,716	$4,076,138
		TOTAL	$9,152,338,331	$7,457,677,674	81.5%			$5,357,273,293	$4,353,704,914

ATTACHMENT 3
COMMERCIAL LOSS RATIO
2006

9/1/2009	2006	PAGE 30.NJ	Lg Group		Sm Group	Sm Group	Sm Group		Individual
	NAIC	Company	Loss Ratio		Premiums	Claims (w/dvd)	Loss Ratio		Premiums
2006	55069	Horizon Healthcare Svcs (BCBS)	85.4%		$799,853,472	$677,471,229	84.7%		$89,088,510
2006	95287	Aetna Health (NJ)	73.7%		$1,132,991,026	$936,032,603	82.6%		$35,217,116
2006	78026	Oxford Health Ins	75.7%		$414,209,414	$331,489,305	80.0%		$65,537,460
2006	95529	Horizon Healthcare of NJ (HMO)	72.1%		$237,961,110	$179,928,022	75.6%		$144,076,439
2006	95506	Oxford Health Plan of NJ	73.1%		$239,007,677	$179,255,758	75.0%		$24,017,382
2006	95351	Health Net of NJ	80.4%		$243,513,819	$188,731,889	77.5%		$3,515,481
2006	95044	Amerihealth HMO	89.8%		$167,664,257	$143,026,230	85.3%		$20,640,141
2006	62308	Conn Gen Life Ins Co	84.3%		$17,563,272	$13,203,944	75.2%		$0
2006	60061	Amerihealth Ins Co of NJ	82.5%		$75,101,110	$67,701,718	90.1%		$0
2006	79413	United HealthCare Ins Co	86.0%		$2,461,475	$1,735,014	70.5%		$48,034
2006	95500	CIGNA Health Care of NJ	83.5%		$38,294,335	$34,530,275	90.2%		$4,046,408
2006	60054	Aetna Life Ins. Co	55.5%		$7,771,660	$5,835,322	75.1%		$1,139,367
2006	64246	Guardian Life Ins Co of Amer	64.3%		$9,359,250	$9,223,392	98.5%		$31,986
2006	95433	Wellchoice HMO of NJ	82.4%		$13,108,747	$10,140,141	77.4%		$0
2006	80314	Unicare	96.0%		$0	$0			$0
2006	81264	Nippon Life	100.3%		$3,825,188	$2,868,891	75.0%		$0
2006	62863	Trustmark Life	80.2%		$2,888,722	$3,286,635	113.8%		$0
2006	61705	Wellchoice Ins Co of NJ	71.8%		$2,132,180	$2,196,091	103.0%		$0
2006	80926	Genworth (GE Group Life)	84.7%		$0	$0			$0
		TOTAL	81.3%		$3,407,706,714	$2,786,656,459	81.8%		$387,358,324